MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF FAMILY SERVICES

MEDICAL REPORT INCLUDING PHYSICIAN'S CERTIFICATION/DISABILITY EVALUATION

CASE NAME		ADDRESS	
PATIENT'S NAME		BIRTHDATE	CASE NO.
COUNTY	CASEWORKER	LOAD NO.	DATE
TO THE EXAMINING PHYSICIAN	NAME		

The above named person is applying for or is a member of a household which is applying for income maintenance. Eligibility for assistance will be based, in part, on the medical information which you supply on this form. Therefore, please complete the entire form as thoroughly and accurately as possible. We need to know if this person has a mental or physical disability which makes him unable to function at his normal occupation or other suitable employment. After an examination has been completed and/or the medical information entered on the form, your opinion is needed about the person's mental and/or physical condition with regard to employability.

NOTE: The Division of Family Services **will not** assume responsibility for payment of inpatient costs unless **prior** written authorization is given by the County Director of the Division of Family Services office which initiated this form. If you feel that hospitalization is required before you can make a decision regarding employability, indicate this on the form and return it to the Division of Family Services County Office.

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

ARE YOU NOW OR HAVE YOU TREATED THIS PATIENT IN PAST YEAR? ☐ YES ☐ NO IF YES, DATE

BRIEF CLINICAL HISTORY (CHIEF COMPLAINTS)

HAS PATIENT BEEN HOSPITALIZED WITHIN THE PAST YEAR? ☐ NO ☐ YES IF YES ▶	HOSPITAL	DATE

COMPLETE FOR EACH PERSON		BLOOD PRESSURE		HGB OR HCT IF INDICATED		URINALYSIS	
WEIGHT	HEIGHT	SYSTOLIC	DIASTOLIC	HGB	HCT	SUGAR	ALBUMEN

EYES		VISION CORRECTED BY GLASSES TO		EARS: HEARING (ORDINARY CONVERSATION)	
RIGHT	LEFT	RIGHT	LEFT	RIGHT (20 FT.)	LEFT (20 FT.)

NOSE, THROAT, MOUTH, NECK (ABNORMALITIES)

CARDIOVASCULAR SYSTEM

CARDIAC ENLARGEMENT?	DEGREE	MURMURS	RHYTHM

EVIDENCE OF CARDIAC DECOMPENSATION, BASILAR RALES, LIVER ENLARGEMENT, PERIPHERAL EDEMA?

ANGINA PECTORIS? DESCRIPTION OF PAIN AND AMOUNT OF EXERTION REQUIRED TO PRODUCE IT

PULSE RATE	DYSPNEA	CYANOSIS	EDEMA	TYPE OF HEART DISEASE	FUNCTIONAL CLASSIFICATION

PERIPHERAL ARTERIAL DISEASE? ☐ YES ☐ NO ABSENT PULSATION? ☐ YES ☐ NO	IF YES, DESCRIBE
VARICOSITIES? IF YES, DESCRIBE ☐ YES ☐ NO	**PULMONARY FUNCTION**

RIGHT	LEFT

NERVOUS SYSTEM

PARALYSIS, SPEECH, GAIT, REFLEXES: PUPILLARY, KNEE, BABINSKI, ROMBERG

EVIDENCE OF	EXPLAIN
☐ PSYCHOSIS ☐ NEUROSIS ☐ MENTAL DEFICIENCY	
SEIZURES ☐ NO ☐ YES IF YES ▶	TYPE / FREQUENCY OF ATTACKS WITH MEDICATION

NEOPLASMS

SITE	BENIGN	MALIGNANT	METASTASES

BONES, JOINTS, AND EXTREMITIES

DESCRIBE DISEASE OR INJURY & STATE LIMITATION OF MOTION, SUCH AS ABILITY TO WALK, STAND, BEND, STOOP, GRASP, ETC.

ABDOMEN

☐ SCARS ☐ TENDERNESS ☐ MASSES ☐ PALPABLY ENLARGED ORGANS ☐ HERNIA — DESCRIBE

GENITO-URINARY

☐ URETHRAL DISCHARGE ☐ HYDROCELE ☐ EPIDIDYMITIS ☐ PROSTATE ☐ ABNORMAL TESTICLE

GYNECOLOGICAL

☐ PROLAPSE ☐ CYSTOCELE ☐ RECTOCELE ☐ CERVIX ☐ ADNEXA ☐ PREGNANT — EXPECTED DELIVERY DATE

ANO-RECTAL

☐ HEMORRHOIDS ☐ PROLAPSE ☐ FISSURES ☐ FISTULA

OTHER LABORATORY FINDINGS (ATTACH WRITTEN REPORT OF X-RAYS, EKG, OR OTHER LABORATORY FINDINGS)

DIAGNOSIS

PRIMARY

SECONDARY

KNOWN MEDICATIONS

SUMMARIZE FINDINGS WITH EMPHASIS ON FUNCTIONAL CAPACITY

IS FURTHER DIAGNOSTIC EXAMINATION INDICATED? — TYPE

DETERMINATION OF INCAPACITY: In my opinion this individual (☐ has, ☐ does not have) a mental and/or physical disability which prevents him from engaging in that employment or gainful activity for which his/her age, training, experience or education will fit him/her. When evaluating a child, the physical or mental impairment has to compare in severity to an impairment that would make an adult disabled and evidence of marked restriction in daily age appropriate activities must exist.

DURATION OF INCAPACITY: In my opinion the expected duration of disability/incapacity will be ☐ one month, ☐ two months, ☐ 3 months, ☐ 4-6 months, ☐ 6-12 months, ☐ 12 or more months ☐ permanent.

THE ABOVE FINDINGS AND STATEMENTS ARE BASED ON MY EXAMINATION AND/OR RECORDS.	SIGNATURE OF PHYSICIAN	DATE